SECTION 5
ELIGIBILITY RESTRICTIONS

A recipient must be eligible for Medicaid on each date a service is provided in order for a provider to receive Medicaid payment for those services. This is also a requirement even when the service has been prior authorized. It is the provider's responsibility to verify a recipient's Medicaid eligibility. The following ME (medical eligibility) codes have restricted dental benefits:

55-Qualified Medicare Beneficiary (QMB): A mandatory coverage group under Medicaid providing payment for qualified individuals of deductible and coinsurance amounts for *Medicare covered services*.

58 & 59-Presumptive Eligibility (TEMP): Coverage is limited to ambulatory prenatal care services only.

80-Women's Health Services: Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases (STDs).

82-Missouri Rx: Recipients only have pharmacy Medicare Part D wrap around benefits through the MoRx.

Limited Benefit Package for Adult Categories of Assistance

Senate Bill 539 passed by the 93rd General Assembly became effective August 28, 2005. Effective September 1, 2005, adults (age 21 and over) in the following categories of assistance receiving a limited benefit package are eligible for dental care only if it is related to trauma or when the absence of dental treatment would adversely affect the recipient's preexisting medical condition.

01 Old Age Assistance (OAA)
04 Permanently and Totally Disabled (APTD)
05 Medical Assistance for Families – Adult (ADC-AD)
10 Vietnamese or Other Refugees
11 Medical Assistance – Old Age Assistance (MA-OAA)
13 Medical Assistance – Permanently and Totally Disabled (MA-PTD)
14 Nursing Care – Old Age Assistance (NC-OAA)
16 Nursing Care – Permanently and Totally Disabled (NC-PTD)
19 Cuban Refugee
21 Haitian Refugee
24 Russian Jew
26 Ethiopian Refugee
83 Presumptive Eligibility – Breast or Cervical Cancer Treatment (BCCT)
84 Regular Benefit – Breast or Cervical Cancer Treatment (BCCT)

Dental services for individuals in the above categories of assistance may be provided if the dental care is related to:

- Traumatic injury of jaw, mouth, teeth or other contiguous (adjoining) sites (above the neck).
- Medical condition when a written referral from the recipient's physician states the absence of dental treatment would adversely affect the stated preexisting medical condition. This referral must be maintained in the recipient's record and made available to the Division of Medical Service (DMS) or it's agent upon request. The referral must include the referring physician's name, provider number, type of dental services needed and the medical condition that would be adversely affected without the dental care.

Medicaid eligible adults in the assistance categories for pregnant women or the blind and vendor nursing facility residents continue to receive the full comprehensive benefit package.

Additional information regarding the limitations and restrictions for the above categories of assistance can be found in Sections 1 and 13 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.